STANDING COMMITTEE ON PUBLIC ADMINISTRATION

INQUIRY INTO THE PATIENT ASSISTED TRAVEL SCHEME

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 15 SEPTEMBER 2014

Members

Hon Liz Behjat (Chairman)
Hon Darren West (Deputy Chairman)
Hon Nigel Hallett
Hon Jacqui Boydell
Hon Amber-Jade Sanderson

Hearing commenced at 9.45 am

Mr PETER COLLARD
Manager, Governance, WA Country Health Service, sworn and examined:

Mr JEFFREY MOFFET
Chief Executive Officer, WA Country Health Service, sworn and examined:

Mrs TINA CHINERY
Chief Operations Officer, Southern, WA Country Health Service, sworn and examined:

The CHAIRMAN: Good morning. There are two other members of the committee I am hoping will arrive. I know one has a crisis that he has to deal with before he gets here this morning, and another who will arrive soon. But let me do the introductions. I am Liz Behjat; I am the member for North Metropolitan Region and the chairman of the committee. To my left is Hon Amber-Jade Sanderson from the East Metropolitan Region. Hon Darren West will come in; he is from the Agricultural Region and the deputy chair of the committee. This is Felicity Mackie our advisory officer legal. Hon Jacqui Boydell is from the Mining and Pastoral Region. And Hon Nigel Hallett from the South West Region will get here eventually, I am sure. Now you know who we all are. You have probably all given evidence at estimates hearings and are old hats at this, but I just have to go through the formalities of it. Starting from the left, could we just get you to take an oath or an affirmation.

[Witnesses took the oath or affirmation.]

The CHAIRMAN: You would have all signed a document entitled "Information for Witnesses". Have you read and understood that document?

The Witnesses: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard and a transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones and try to speak into them and ensure that you do not cover them with papers or make noise near them. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege. That is the formal bit over and done with. Please just be very relaxed about the hearing and we will use first names and things like that, I think. There is no need to stand on formality here today.

[9.50 am]

I will say that this has become a very interesting inquiry. It started out an interesting inquiry but it has become even more interesting as we have had the opportunity to travel around the state. You probably are aware, but just so that you do know, we have, in the last early two weeks, visited Carnarvon, Kalgoorlie, Albany, Port Hedland and Broome—those regions and the hospitals—and we have taken evidence from the country health people there, but also from private citizens as we

travelled around. It has certainly become a very interesting inquiry. We have found that it is very different in every region. Today, we thought, is a really good opportunity to have a chat with you to somehow try to bring it all together, but even then today we have just found that there is a different way that things are administered in the south west. We will be canvassing some issues surrounding that, because we are planning to go to Bunbury and Northam so that we can then say that we have travelled to the seven WACHS regions because we think that any good inquiry would do that; each of the regions are covered. What we have done is seen the PATS officers and talked about the administration of PATS in those regions. But we have just found out that with the south west it is different, so in Bunbury there would be little point us doing that when we do go there, so we will talk to you guys about how that is administered.

The information that we are asking for is quite specific—I know you have given us a briefing note here and I think we have seen some of this information before, some of it we have not—so if there is anything that you do not have with you today, we are very happy for that to be put on notice and you can provide that to us at a later date. This inquiry is not being hurried to a very rapid conclusion; we just want to make sure that we get much information and so we have time to gather everything that we need.

The first thing we were wanting is some general statistical information. So, let me just run through the questions that we have here. For each of the last five financial years, please provide the following information: the total cost of payments made under the scheme, broken down by transport, by type and accommodation payments; the total cost of administering the scheme—I will run through this list and then you can tell me whether you have those; you might have to take this on notice—the amount of money spent on advertising and promoting the scheme in total and by region; how many patients submitted applications for assistance after travel; the financial contribution to PATS from the royalties for regions fund; how many patients access the scheme by medical condition; how many trips were subsidised broken down by single trip versus multiple trips; the number of patients in each WACHS region who accessed the scheme; and a breakdown of the number of recipients who accessed the scheme who have a concession card, by type if possible. That is all fairly detailed and I would imagine that you do not have that with you today, so would you like to take all of that list—we can talk about it in general terms, but given that you will not have those specifics for the five years, do you want to take that on notice?

Mr Moffet: Yes. We have made quick notes. Is it possible just to confirm or get a written statement of those?

The CHAIRMAN: If we put that on notice, you will get that this is what we have put on notice. The general statistical information is A1 and that will be put on notice.

[*Supplementary Information No A1*.]

Mr Collard: It might be just a couple of those that we cannot provide. Most of it, I think, we can probably provide for either some of the years or most of the years. But things like whether they are a Health Care Card–holder, we do not capture that information within the PATS environment.

The CHAIRMAN: That is interesting. Is there a reason why you would not capture that?

Mr Collard: The way we operate PATS policy, it is not a requirement—same with Aboriginality. We do not capture that sort of information or whether they are going to private or public specialists. We do not differentiate where they are going within the PAT scheme.

The CHAIRMAN: The Aboriginality question is quite interesting then. We have got three hours with you, so we will just sort of range over, and one of the things we found out is that there is this Country Connect program put in place ostensibly for Aboriginal people. So, if you do not capture that information—is it not then the PATS responsibility to hook them up with Country Connect or is that someone else that has to do that part of it?

Mr Moffet: It is an elective service. If Aboriginal clients want to access that service, they are directed at provider level, but not all Aboriginal clients will necessarily access Country Connect.

The CHAIRMAN: Is that part of the PATS normal thing? You say, "There are things available; it is up to you whether you want to access them or not"? How would they then find out?

Mr Collard: Access to the Country Health Connect service is generally through the PATS coordinators and PATS offices in the regions. They would know the clients who would require or benefit from that service and would generally make that referral to the Country Health Connect service.

The CHAIRMAN: Whilst you do not collect the data on Aboriginality, you rely on the person sitting in front of you saying, "I think they are Aboriginal, so I will offer them this service"?

Mr Collard: I guess. Most of the people would know the clients that they are dealing with in the regions.

Mrs Chinery: I think, if I may, Country Connect is also there for the metropolitan services; so, if a client has come down and been flown down by inter-hospital transport. It was set up separately to PATS and, as you have probably observed, we have seven different ways of administering PATS. PATS has only become more centralised in the last couple of years. I think you have probably picked up that the two are not always necessarily coordinated together. We have set up a working party where Country Connect is through the administrative area. We are looking at how the two work together, but that is a sort of evolution. It was set up separately to PATS.

The CHAIRMAN: When we have been taking evidence, one of the issues that has sprung up with regard to Country Connect is that there is not a lot of coordination. What is happening is you have got some people coming from regions on a bus and the bus might get into Perth at nine o'clock at night or two o'clock in the morning and Country Connect works Monday to Friday, 9 to 4. So, it is not a terribly efficient service, I would say. That is something we can talk about a bit further on. The first question that we have really asked the WACHS people as we have gone around the regions, which we would now like to ask you today, is if you could outline the efficiencies and deficiencies of the PAT scheme as it currently stands?

Mr Moffet: Just before we do that, can I just clarify another point on Peter's line? I think you had a question by medical condition as well. We can provide medical subgroups, if you like, and the specialty subgroups.

The CHAIRMAN: Renal, cardiac, cancer, that sort of thing, not by specific broken leg; we do not need to know that.

Mr Moffet: Sorry, your question was on efficiencies and deficiencies.

The CHAIRMAN: Efficiencies and deficiencies of the scheme—that was our opening gambit at every place that we went to, so we thought that was probably the best place to start today.

Mr Moffet: I will start and Tina and Peter can add. From my perspective, I guess, in terms of efficiencies, we have got quite a distributed network in terms of access to the scheme, so it has got a lot of profile at each hospital level. That brings its own challenges obviously. Fundamentally, we have a base at every hospital level around PATS, so I guess that is one of the efficiencies, effectiveness features, of the scheme, so it is quite profiled, if you like, in the public system as opposed to a highly centralised remote online service, for example. You could regard that as something that is quite patient-facing. I guess one of the challenging areas for us as a health service is that we do provide a lot of case management as well. It is not just a subsidy or a reimbursement scheme alone. It is not just a financial scheme. We wrap around services, such as Country Health Connect. We provide bookings for travel and accommodation and we also end up managing aspects of those issues for more vulnerable people. From an effectiveness perspective, I think that is

probably a strong feature of the scheme—a lot of case management—although it is an area that we think we could improve.

[10.00 am]

I guess you have seen the jurisdictional comparison. The scheme compares fairly favourably with most metrics compared to other jurisdictions, if you like. It is a subsidy scheme, so it is very limited. But if you look at some of the metrics and measures in the comparative analysis data attached to the submission originally—the minister's submission—it is a scheme that provides, I guess, contemporary or at least at or above national standard, if you like, benefits or advantages for clients. On deficiencies, there is probably a similar set of issues in lots of ways. The inherent challenge of the scheme is there are hundreds of thousands of transactions every few years, so it is a very high volume scheme. It is a scheme designed to be as equitable as possible, but, inevitably, with issues around human conditions, travel circumstances, place of residency and circumstances that vary from client to client, it is very hard to find a scheme that in all circumstances is perceived to be equitable by its recipients, and I am sure you have heard that. It is very difficult to have a scheme perfectly respond to all circumstances at all times. I guess that is one of the challenges of the scheme. I think in our submission we have set out some areas where we think some effectiveness could be made. We would like to see a more web-based online system with stronger information systems to support both applications from providers that refer for PATS, as well as from families. So, we would like to see better information systems, if you like, to improve efficiency, management reporting and transparency of the scheme. Inevitably, I think we have provided through the minister some areas for consideration around circumstances that might provide a little more flexibility—for example, obstetric patients and families, amongst others—acknowledging that it is a scheme that always has a boundary at some point. So it is very difficult to design where those boundaries should start and end, and that is ultimately a matter for government to decide on from a policy perspective.

Mrs Chinery: I might add that, with the efficiencies, we have, as you have met, the PATS clerks that are out in the regions already and they are doing other jobs, so we are actually quite efficient in the regions where a community member can go into a hospital and the ward clerk, who is not a PATS clerk, can make sure the form gets to the right place. I think that, in a way, by having that local administration, there are some good efficiencies. Local staff also have a good understanding of the issues that are faced by people trying to travel, because they are travelling themselves and trying to navigate the system. I actually think they advocate very well for the people because they are local. We have looked at a centralised system, but you may lose some of that local support and knowledge.

In regards to deficiencies, there are the number of steps you have to take for the form—the size of the form and the fact you have to reapply. If you have a chronic disorder, you have to keep lodging a form. I think that is extremely distressing and bureaucratic, and we are looking at that and are trialling a two-page form. Also, having been the regional director for the Pilbara in the past and having to make decisions around people's transport, it is quite significant for them around whether or not they are eligible in an exceptional ruling case to take their family to Perth when they have potentially been diagnosed with something very serious. I think that it is very difficult for the decision-makers, and we should have some robust support around those decision-makers because humans will make different decisions. I think the challenge is to make that exceptional ruling decision-making much more consistent, so we have put in some draft procedures. But, again, I think that is an area that needs addressing from an administrative process.

The CHAIRMAN: Certainly, one thing I do want to say is that every person we spoke to—not the people involved in WACHS but the private individuals who came and spoke to us during that time—all value this scheme greatly and there was certainly a recognition throughout all the regions that it is a very valuable scheme. I think there was a bit of angst amongst people there that the

purpose of this inquiry was to look at shutting down the scheme, so we were certainly out there trying to allay those fears that that is not our purpose in this inquiry at all. But do you think that perhaps one of the deficiencies of the scheme is that what is covered under PATS has not kept pace with advances in medical technology and what is available? With allied health, for instance, we know now a lot of those things which previously may have come under the allied health banner really are quite mainstream. I suppose the classic example that we have used in most of the places now that has become quite public is the issue of cochlear implants. The surgery is covered under the PAT scheme because that is a surgical matter, but the most important part of the implant is the three follow-up visits with the audiologist to have the implant turned on once the healing has taken place, yet that is not covered. But, of course, probably at the time that these PATS guidelines were written, cochlear implants were not done on the same regular basis that they are now. Do you think that is really something that needs to be looked at as to whether we are providing enough in that allied health area?

Mr Moffet: I think the minister did include in his submission that we prepared some points around that. If you go back 20 or 30 years, it is fair to say probably what we call the service model or the model of care was much narrower technology, but the way in which services were provided was more medically oriented, if you like. So, increasingly we are seeing the scope of practice for nurses and allied health professionals increase. Having said that, there are some allied health services that existed back then, such as specialised seating clinics, that have never been supported. It has always been an issue of contention, if you like, or concern for clients that need access to specialised therapy services. I think it is true to say that the way in which services have grown and evolved over time does mean that you need other than medical specialist services to provide the full spectrum of care. I guess there has been an intentional boundary put around the program in the past in terms of dental and allied health. It is probably a source of the most feedback and concern from country consumers.

The CHAIRMAN: So, if it was up to you, what would be the allied health services that you would include?

Mr Moffet: I guess it is a bit difficult for us because we administer the scheme and it is matter of government policy, except that in the minister's submission we did have a section on this that the minister had endorsed in terms of some specialised tertiary-level, if you like, allied health services and dental services. I guess we see those as logical; it is logical and reasonable that if you cannot literally access those services in country areas, and the metropolitan centre is the state-based centre for care, those sorts of services should be accessible. Having said that, the primary and secondary basic allied health and dental services, I guess, are an area of consideration. If you make tertiary-level dental and allied health services available, a question could well arise about why access to primary and secondary dental and allied health services was not supported as well. I guess the general point there is that those are generally available in country areas, but not exclusively—not everywhere. Does that make sense?

The CHAIRMAN: Yes.

Hon AMBER-JADE SANDERSON: You talked a bit about the consistency of exceptional rulings, and that has come up consistently. One of the proposals or suggestions was that other regions kind of cross-reference other regions' decision-making. Is that something that the department is thinking about and could it also help with the communication of what is being considered exceptional in the Pilbara versus the great southern?

Mrs Chinery: Yes. The working party was set up post the OAG review of the PATS administration. We set up a working party and out of that working party, the first procedure we have redefined clearly amongst ourselves as the seven regions has been the exceptional-ruling process. The idea is that then they are centrally maintained so that each of the regions can do some cross-referencing. That is on our list and I think, Peter, that the standard procedure is almost ready to go to our executive for approval.

Hon AMBER-JADE SANDERSON: In the briefing note and in your submission, you made, I think, what is a really sensible suggestion for indexing the payments. What would you index it to, ideally?

Mr Moffet: I guess we would just expect indexation alongside the normal health indexation formula.

Hon AMBER-JADE SANDERSON: Is that the same as NGHSSI or CPI, or is that different?

Mr Moffet: It is generally an agreed rate specifically between us and Treasury. That does vary a bit over time, but it is intended to reflect demand, if you like, in the system.

[10.10 am]

Hon AMBER-JADE SANDERSON: In health costs, so it is separate to CPI?

Mr Moffet: Yes, it is like medical service index terms, so it is slightly higher than CPI generally—not always, but generally. It tends to accommodate a level of demand growth as well and it does vary from time to time as demand in the system varies. PATS does not perfectly follow the general state demand but there is a reasonable correlation between transport systems and services demand.

Hon JACQUI BOYDELL: Jeff, I note in the submissions the suggestion that the web-based program will be a much easier way to administer the program. This is not rocket science to you guys; this is your business. We are going over what you probably already know. Why are we not doing that; is it simply a lack of funding? Is there a lack of IT depth and knowledge? What has stopped that from happening already?

Mr Moffet: I will defer to Tina and Peter in a second. My understanding is that we have not been resourced specifically to develop that system. The resources that come into PATS are targeted very heavily towards system administration and delivery of PATS reimbursement. One-off additional funding would be required to develop a web-based system, which I presume is what we would be looking at—Peter?

Mr Collard: Yes.

Mr Moffet: I do not think we have had the specific resourcing. Recently we have been suggesting that. We are certainly very keen to modernise access to the system for providers, clients and ourselves.

Hon JACQUI BOYDELL: Do you have a model already; have you researched what you think from an IT perspective is viable to deliver; do you know that already? If you had a specific pot of funding tomorrow that said do this, do you know what you would have?

Mr Moffet: We would have to go through the usual software design process—functional specification and design specs.

Hon JACQUI BOYDELL: You have not done that already?

Mr Moffet: No. Is that right, Peter?

Mr Collard: Not at that level of detail. One of the plans was that we would need to scope out the development of that. One of the complexities with PATS is that we are very reliant on the general practitioner filling out a certain amount of information and we require them to identify whether a person requires air travel or an escort, which might be outside the normal scope of the policy. Again we are reliant on the GP to provide that information. It is a matter of trying to get that information collected from the GPs. We have been looking at some systems where that can occur. The other complexity is that at the other end when the patient goes to the specialist, getting a specialist—the majority of them are in the private sector—to certify that a patient has attended. That is quite straightforward but if there are some special requirements: does the patient require additional night's accommodation? Do they need an escort to support them going back after treatment? Do they warrant an airfare because of their clinical condition? It is often not necessarily

the condition they are presenting for that determines that they do need the escort or the airfare. It might be an associated condition. They might be frail or have some other medical —

The CHAIRMAN: Complications post-surgery?

Mr Collard: They just might have some other medical conditions that require them to be supported with an escort to help them make those sorts of decisions, which might not necessarily be related to the treatment they are receiving at the moment. It might be something else that they have. That is why it is difficult for the PAT system to identify that and make those decisions without the clinical input. As I said, most of the specialists and also GPs are private; they are not tied into our systems necessarily so we have to interface with them.

The CHAIRMAN: One of the issues that were surrounding that when we were traveling was that the GPs themselves, especially in smaller areas, sometimes—I do not want this to reflect on the way GPs carry out their business, but they are very busy so the quickest thing to do is to tick the form, going "Yes, yes, yes, you can travel and you can have taxi vouchers and I need to see my next patient", because we know the pressure GPs are under generally. It seems that in an ideal world a web-based system would be generated by the GP at the time of that visit, which means your form would then be populated because every practice we go to these days has some sort of computer-based practice management system so the patient's information will be there. The PATS clerks and others who are administering this scheme told us that they have to go back to the GP quite often to get further and better particulars on why they said yes to the airfare. If that was incorporated in the form at the very beginning, you would obviously save a lot of time and energy wasted in going backwards and forwards to do that. Presumably, all specialists have online systems. Every time I have been to a specialist, the results have been sent to my GP with copies of everything, scans et cetera, electronically, so, obviously, that system would exist and I think would be a much more efficiently run and more equitable system. I do not think it is beyond the scope of what can be done.

Mr Collard: No; it is not beyond the scope.

Mr Moffet: It is absolutely possible. I came from the NT six months ago and the NT has implemented a similar system to the one we are talking about. Your point that there is a bit of discipline and mandation around an online system also requires a bit of change management. So you would want a web-based system to automatically populate the majority of fields from their own software, as you say. Going to automated systems does eliminate shortcuts, subjectivity and gaps. That can be frustrating for users as well, so it is a matter of designing a system that is efficient, quick and effective but makes sure that before you proceed to close an application, all the information is there. So there is a bit of change management introducing software, as you know, for use of providers or, in fact, for any users.

Mrs Chinery: For our residents, we think that it is not just the data system; WACHS would have to set up a case-management model where a set of people can look at that clinical case and care for people who require extra support. That data system would be very good for people who are comfortable claiming online and have access to computers and things like that. As you have experienced when you have travelled, a large group of people will need our continued support and which our staff do give. When we did the first review of how we can review the administrative model for PATS, it had the proposal that we need to investigate the web-based system as well as the case-management model for vulnerable people.

Hon JACQUI BOYDELL: I was going to touch on this later but as we are talking about GPs and how the system is managed, I think one of the biggest things I certainly picked up is the communication between the GP, the PATS clerk and then the patient. In most of the anecdotal evidence I hear, certainly when I am out and about in the electorate, is that in some areas it is the PATS clerk who is going back to the patient and saying, "No, you don't qualify, although the doctor said you can have air travel, you actually can't." I think it was in the Kimberley where there is a different structure that the communication goes back to the treating doctor and they communicate

with the patient. I get all the reasons for that, but there is almost a feeling of a lack of compassion within the system because of the very hard-nosed administrative process that has to occur. If we had that online system, at the end of the day it would have to come back to the treating doctor, I would have thought, to make that call. I think the Gascoyne is one case in particular. In the Pilbara and Kimberley you have air travel and you are already recognised as having air travel. It does seem to be a bit of an issue, from my perspective dealing with people in my electorate, that the doctor said in the Gascoyne I could have air travel, but the PATS clerk has said no. There seems to be no real management around how you deliver that information to people. If in the first instance you had the system of the GP being able to, I guess, responsibly give information from a populated form to the PATS clerk, that might eliminate that misconception from the patient that nobody is recognising the stress they are under. Do you have any comment to make on that?

[10.20 am]

Mr Moffet: If there is a particular issue that you have come across, we will certainly take that away and assess it and see whether it needs to be changed or improved. We are very happy to do that. I think it touches on the issue around expectations and understanding of the scheme's limitations per se full stop. Since the scheme has been in place—a commonwealth scheme—there has always been a limit as to what it can and cannot do. The nature of who communicates the information around either declining or not being able to fully meet a patient's expectation around air or road transport has always been a difficult issue. Some clinicians are comfortable with the scheme enough to interpret it and provide that advice to their patients. Others are not comfortable doing that, or still have a query as to whether a patient is eligible or not. It is often left to the administrators of the system to communicate that. It is an area that is always tricky and contentious. I have administered PATS directly in the north west, the Kimberley and the Pilbara as well, and it is difficult sometimes, particularly clients who have lived in Perth for a period of time are used to a certain level of access to services. When they come and reside in a remote part of the state, they expect to maintain continuity of care from a specialist provider in Perth and realise that the scheme is not there to do that.

Hon JACQUI BOYDELL: Jeff, when you get, say, a locum and they do not understand the scheme, is there a step-in process that WACHS runs for those doctors to help them understand what is required before you would send someone off on a PATS journey that they are not qualified for?

Mr Moffet: There is orientation information. Rural Health West, for example, provide rural GPs, if you like, with information and guidelines around —

Hon JACQUI BOYDELL: Who runs that? Is that in the introduction by the hospital that they go to or —

Mr Moffet: No. It is a set of documentation essentially; sort of a starter park on PATS and what it is about. Many GPs will be overseas-trained doctors as well. Rural Health West provide that as part of a package of information. I think it is fair to say that when you start, there is a lot of information to absorb. How you make the PATS information most relevant, I do not know. I know our regional medical directors and staff locally do engage with doctors as well intentionally. It is not to say that there are not gaps, but we do work really hard to get information out to referrers. With a turnover of 20 to 30 per cent at times, that is constantly evolving. Often you end up with the situation where the most continuous contact is the PATS clerk or the operational people in the hospital who tend to fall into a role of conveying information more routinely.

Your point is a good one. I think air travel in Carnarvon, and probably Kalgoorlie, are good examples of residents in those areas who do not automatically meet the air travel test. One could argue reasonably whether that is difficult for some clients or not, so you do very much rely on good assessment by clinicians to say this client does need air travel for medical reasons essentially. But when there is a "no" to that, or people do not meet the guidelines or perhaps they have had

different decisions at different times depending on the status of their condition, there is often disappointing news to deliver. I think that is always difficult.

Hon JACQUI BOYDELL: Something that was brought up in a number of regions that we travelled to was escorts. I think the process is very clear when an escort is required for clinical purposes. When it is not clear, and I think probably people are falling to "exceptional circumstances" to help support the patient, is in terms of English as a second language or for cultural requirements. They are very real things to those patients in dealing with their medical condition. It is a very real part of the healing process that they require that support. Do you have any comment to make in your experience of dealing with PATS that we should be looking at extending? I know that is a government policy position; I understand that. Do you get a lot of feedback about that from your regional directors?

Mr Moffet: I have only been back six months, so I probably have not had a lot of feedback in that time. But I guess over a long period of time being involved in PATS in different places, I think the provision of escorts—it is often more than one escort; for example, during periods of confinement for deliveries—is difficult because a normal family circumstance would be that other members who are close to them would be present and sometimes more than one, especially other children for deliveries, or for cancer treatment or significant health events in people's lives. It is a very difficult area. I think it is a very emotional area for clients. The submission again made observations that a more flexible provision of escorts might be something that the committee could consider. It is difficult for us to say whether that should or that should not happen, given our role, that is all.

Hon JACQUI BOYDELL: I understand that is difficult. A lot of the evidence that we have collected is certainly that seeming lack of compassion for or understanding of the circumstance. I am sure that that is not the case.

Mr Moffet: To touch on that point, it does take us in the direction of exceptional rulings, obviously. It is very difficult for absolute consistency on each and every occasion to occur, so it does lead to variations in judgement. I do not think anyone is intentionally non-compassionate. There is a balance in the administration of the scheme and the broader intent of the scheme and when do you essentially step outside of policy with an exceptional decision. It is an area that we have observed and we probably need to try to be more consistent on. But it is that area where there is a boundary to the scheme and for those who fall just outside of it, it is disappointing. For us as a health provider, obviously we want people to feel supported and comfortable in their care, particularly if they are vulnerable. Whether it is English as a second language or different ethnic backgrounds, we want their health experience to be as normal as possible. It is an important part of their recovery, as you say.

Mrs Chinery: It is very complex. I agree with Jeff, I think that is a gap. I want to support what Jeff is saying. It is extremely difficult to ensure consistency across decision-makers. We have done as best possible with the system that we have, but I believe that that is open to not having consistency necessarily. You may find in one region someone has had one put through and in another they may not have been put through. I think it makes it even more difficult when consumers find out about that.

Hon JACQUI BOYDELL: I agree.

Mr Moffet: From time to time there are examples provided where clearly a different decision probably should have been made. There are not many of those, but obviously just one decision can attract a lot of attention.

Hon JACQUI BOYDELL: When we were in the Pilbara, we heard about the trial of the one page. Today, Felicity has given us the south west one page. I am not sure why we have a trial working in the north, but seemingly we have the same process already occurring, and why people are wasting their resource on reinventing the wheel.

Mr Collard: I guess in the north west and also in the wheatbelt, the types of client base that they are dealing with are slightly different in the south west, although the wheatbelt is very similar to, I guess, the south west where most of the claims are retrospective claims. They are just for some kilometres and maybe overnight accommodation. In the north west, obviously, they are coordinating airfares and that sort of travel a lot more. We wanted to look at some of the different elements based on feedback that those regions had received regarding completing the form, to trial a slightly different form. The south west one, my understanding is—I am not 100 per cent familiar with that one—it is the way that they actually receive their initial referrals. They get their referrals faxed from the GPs into the central service. The specialist forms are then posted out to the patient to take when they go to the specialist appointment. There is a slightly different process involved in the south west because of that contract arrangement.

Mrs Chinery: The trial form is based on feedback from the OAG. We were missing things, like the Medicare number was not being recorded up-front. In fact, that form has been developed in response to some of the governance issues identified. On top of that, we think that that form has been designed to be electronic at a later date. The south west does have a different administrative process from the rest of the regions, so that is how that form came about. We think that it is valuable trialling that form, and potentially the south west will go to that form.

[10.30 am]

Hon JACQUI BOYDELL: That form is slightly different, from memory, in that it has the specialist form included.

Mrs Chinery: The south west one is still a two-step form because you have still got the forms to go.

Hon JACQUI BOYDELL: Okay, that clarifies that for me, thank you.

The CHAIRMAN: I have got some other questions I want to ask about the whole form thing in the south west PATS, but I might go to Amber-Jade, if you have got things we have already canvassed rather than moving to a new section.

Hon AMBER-JADE SANDERSON: I want to jump back to PATS staff. First of all, I thought the department's submission was really useful and it demonstrated a sort of working empathy for people using the system. In terms of staff, we have heard a lot about how difficult it is to be a PATS administrator and we have also heard from users of the system who find PATS administrators immensely frustrating. They are stuck between a rock and a hard place administering it to the letter. We saw in the different regions we have been to so far quite different ways of dealing with the challenges of that job. What kind of training is currently provided and could be provided better, and what sort of workplace management needs to be in place to manage those teams and help these people deal with some difficult issues they dealing with?

Mrs Chinery: I could probably answer this and Peter might want to add something. Yes, it is an extremely stressful job. People are obviously distressed when they might ring a PATS clerk, so one of the local things that each of the regions are doing is they rotate staff onto the call system, because it is actually one of those call centre systems. They provide training for staff and recently we have included ethical training as well as records management, which was identified under the OAG review. We are focusing on customer liaison type of training and that is something we will pick up through the working party. We are starting to talk about what other manager requirements there are for staff. If I could, bear with me, go over the history of PATS, it has just evolved. It used to be administered under the commonwealth and then was transferred to the state. My understanding is that it was managed centrally by the department and then given to WACHS. WACHS just had it come across in the budget, so it was not even separate from our day to day budget and it was only back in—I cannot recall the year—they actually identified that that amount of money would be put separately for PATS. I think in terms of any planning models of administering the PATS, that

probably did not occur until probably since 2006–07, and I know the Pilbara centralised its PATS administration at that time. But again, regions were managing it separately and obviously it was a reasonably small program, but as the population has increased—and in 2008–09 when they changed the policy, we had a dramatic increased uptake of PATS. Obviously there was advertising with that policy change and obviously people are very positive about that. I think that is why you have seen this sort of, "What is the plan across the seven regions?" The strategy WACHS is undertaking is to pull together a working party to start looking at centralising and managing as many of the processes as possible consistently across seven regions. Obviously, we are very keen, though, to see what comes out of this, because hopefully you will be able to provide us with some input and feedback too, because I think it has been critical to ensure we get feedback from the community. On the working party there is actually a north community representative and also a southern one. There is a plan to help standardise some of the administrative processes along the way.

Hon AMBER-JADE SANDERSON: In the Pilbara and the Kimberley in particular, we saw differing uses of ALOs. The Kimberley used them quite extensively but in the Pilbara were not really mentioned at all. I wanted to know whether there is a greater role ALOs in terms of that client base, particularly those coming from really remote areas, in that support, in your point of view?

Mr Moffet: Yes, I think so. I think accessibility to ALOs where they are deemed to be required is really important. I am not actually familiar with the differences you are referring to. I imagine it has probably just localised over time, but the use of ALOs, as well as Indigenous staff who have worked with us who are familiar with administrative processes and also community culture, is really important as well. I guessed one of the reasons for Country Health Connection evolving was, I guess, having some cultural knowledge and expertise base in Perth with a high level of compassion and, I guess, a contextual sort of understanding. That has been a very effective program over time, I think in terms of each role in the metro. The other point I should make on that is that there are other schemes Derbal Bidjar and AHCWA also run sort of liaison officer and transport functions, and some of the Aboriginal medical services regionally also provide —

Hon AMBER-JADE SANDERSON: That leads on to my next question. In the Kimberley, for example, we saw PATS supported by a range of other sort of NGO groups or other funded organisations and while for that region it seems to be working relatively well, it gave the impression when we moved to other regions that PATS was a sort of all-encompassing scheme that you could access, and other regions were having to sort of deal with the challenges of explaining, "Actually this is the PAT scheme." This is more of a comment on a question, I guess. There needs to be much greater communication and clarity about what kind of augmented services are provided in terms of that. I guess the question is: is there a role to better educate some of those PATS staff or the local WACHS on how people can access it, rather than just saying, "No, you are not eligible for this, but you can apply here for this."

Mrs Chinery: I think that is the challenge that we get funding to administer the subsidy. It is just a subsidy scheme and where our staff potentially have some connection, they will make more effort to go into the case management model, which we are not actually funded for or supposed to do; it is not acknowledged as a cost and need. If I could comment that the Closing the Gap funding actually has transport officers, including buses and things, so even if AMS was successful in getting those Closing the Gap funds, they obviously have the ability to link in with PATS and potentially do those transport services. That would have been region-by-region submissions, so you will see the varied funding buckets across the seven regions and therefore you are going to have this discrepancy in what our community face and what they have access to.

Mr Moffet: I think, obviously, the Kimberley has almost 50 per cent Indigenous communities, so you would hope and expect a much higher level of focus on services, moving down the state, I suppose, in lots of ways. It would be interesting to know when you finish if you think there is something systemic about that or whether those are some individual patient experiences.

What I would say is that probably the use of the ALOs as well as our cultural competency, if you like, develops over time and it really probably reflects the service and cultural sort of relevance and support services. This would just be a PATS issue. I would suggest that our use of ALOs and dedicated health workers to navigate the system for clients in Broome or Derby is probably what you are touching on. If there are strong features of our services that support the PATS administration from your perspective, we would be very interested to hear about those, just from an independent and impartial perspective. The question for us is if they are systemic how we transfer that systemic nature to the Pilbara, the midwest and other places.

The CHAIRMAN: I think they had a very well-developed system in Broome that we observed there, certainly with their ALOs and the patient waiting lounge they have set up there, and the fact that they had extended the hours to take into account that is not a Monday to Friday, nine to four job. If there was to be an overall model, and I am pretty sure my colleagues share this view, it would probably be a very good starting point for a very good model that seems to work very well.

I want to ask a question about airfares, and probably talk about those regions, because from some of the evidence that was given to us by people from remote Aboriginal communities, for instance, it seems that when airfares are being arranged for people, the guidelines will say that you are to get the best available fare on the day, and we all understand that it comes down to the dollars and who is going to do the best thing. We know that in Carnarvon there is only one company you travel with and so the best on the day is what they can give you and that is it. What would like to know though is that there was evidence given to us in Broome, and we did not hear this specifically in other areas, so we need to know—it might be something just for that area or whatever.

[10.40 am]

We will take the example of mothers coming to Perth because of high-risk pregnancies, and they may need to come here for two or three weeks prior to the due date. That means that they are going to be down here during that time, and if they have come from a remote region in particular they are going to start accumulating gifts or shopping or things like that for the child, as would any mother who is going to be giving birth. Nappies themselves would take up quite a bit of room. Then again, you have the child and you are here for a little while afterwards, so obviously then there will be extra baggage. There was evidence given that we have had Aboriginal women in particular arrive back at the airport to go home. They are going to go on to a commercial flight to get some part of the way there. Eventually to get where they are going they might end up on a mail plane back out to Warburton or whichever community they are going to. However, when they get to the airport on their commercial flight and they have accumulated all of these things with them they are being told at the airport, "Your ticket doesn't allow for you to take luggage because you've got a carry-on luggage only ticket." I can see by the look on your face that that is a surprise to you.

Mr Moffet: I thought you were going to say "excess baggage".

The CHAIRMAN: No, not baggage. Apparently it is not a one-off situation, so I would like to know whether or not that is some sort of directive or a guideline that you only get carry-on luggage, because surely there should be an allowance for people to have a normal amount of luggage with them. Excess, we can understand, if there are prams and things like that.

Hon AMBER-JADE SANDERSON: It is the policy of best price on the day that needs to be looked at, as well as that, because best price on the day is just walk-on hand luggage. So they are getting that, but then when they come back to Perth that all they are allowed to get on.

The CHAIRMAN: Even though with best price on the day you can normally tick a box that says "And I'll add on this to go with it", but I think that is a little bit of a misinterpretation. One would hope this is a misinterpretation of the guidelines and that there was never any intention that a person should only have carry-on luggage on an airfare.

Mr Moffet: I would not think so. I dare say it is an unintended consequence, so I have not actually heard of that. Have you heard of that before?

Hon AMBER-JADE SANDERSON: I think it is fair to say that we heard it a few times; it is not a one-off.

Mrs Chinery: And in particular regions? The Kimberley?

Hon AMBER-JADE SANDERSON: In the Kimberley region in particular.

Mr Moffet: They should have capacity to take the normal 30 kilograms, or whatever it is.

Hon JACQUI BOYDELL: And the Ngaanyatjarra lands.

Mr Moffet: The Ngaanyatjarra lands as well.

The CHAIRMAN: That is certainly one of the things that, if we achieve nothing else, we might be able to get fixed.

I would like to go to the information surrounding the forms themselves and the south west PAT scheme. We will talk specifically about the genesis of that scheme and how it has become quite different to any of the other schemes. You said that the wheatbelt, in a comment you just made, is mostly retrospective in its application, but it would seem that in this south west one there is no ability for it to be retrospective. There is a similarity between the wheatbelt and the south west, but this form that the south west has would seem that only applications for travel registered prior to the appointment would be approved, so there is no way that they can do retrospective in the south west.

Mr Collard: I guess I was referring to the retrospective payments. Under the current policy all PATS applications should be approved before the full travel. In a lot of circumstances in the wheatbelt and other regions they will give people fuel vouchers and those sorts of things as prepayments to assist a person to attend the appointment, and then will either pay any back payment after that or often the prepayment is the same amount of the actual application form. In the south west, it is majority retrospective payments, even though they have preapproval. So that is similar across both regions, but in the wheatbelt a lot of their applications then come back for payment after the person has attended their trip, so that is when they have presented their specialist appointment and receipts and all those sorts of things. That is when the payment is made. It is similar to the south west.

The CHAIRMAN: I want to talk about the south west in particular, and how that all came about. However, noting the time at the moment is 10.45 am, we are in a situation today, unfortunately, with only three of us being here at the moment, that we cannot leave the room because we will lose quorum. What I propose to do is just at the moment we will take a five-minute break so that we can have a comfort stop. Please, if you need to do that, and also if you would like to have a tea or coffee, please do that, and our members can also avail themselves of that. We will just have a quick five-minute break.

Proceedings suspended from 10.45 to 10.54 am

The CHAIRMAN: We have been talking about the differences in some of these regions. It has only just come to our attention today that the south west in particular has a very different way of administering the scheme than any of the other WACHS regions. So if you could just talk us through how that came about and how it is administered, and why that might be a better way of doing it—everything you can about that. If you could just put some flesh on the bones for us about that, that would be great.

Mr Moffet: I guess how the scheme originally came about is that the South West Area Health Service was separate to the rest of the WA Country Health Service up until 2005, so they were separate administrative regions—the country was in two. The South West Area Health Service had a number of programs that they developed over time, and one of them was South West 24.

Mrs Chinery: That included calls for mental health, so a 1800 number to ring the mental health support, and then PATS online.

Mr Moffet: McKesson's originally were contracted to do that, and that has subsequently been subsumed by Medibank Private.

Mr Collard: Yes, Medibank Health Solutions.

Mr Moffet: So it had a different administrative history. It is a scheme, I guess, that runs probably similar to the wheatbelt and aspects of great southern, where you have got very different population cohorts, obviously all drive in, drive out access to Perth and into the region with, generally speaking, not too much case management in terms of the wraparound social services or accommodation bookings or management of various parts of people's destinations. So I think it is working relatively well up until this point. I think one of the considerations for us—again awaiting the deliberations of this committee—is as to whether that model is something that could be effective for the whole of country or not, or that style of model, where you have a more consistent, separately administered service. That obviously raises questions about how you do the case management element. Currently, PATS administration is done in our smaller places by an officer who has a range of duties—not just PATS but all sort of duties, as I am sure you have heard—including making sure that people get on buses and get off buses at certain times and sit in transit lounges, as you know, and also dealing with family members coming and going at various times for those who have longer stays. So there is a case management element that is separate to the administration of this scheme that would need to be considered carefully if we were to change administration to something more akin to the South West 24 model.

The CHAIRMAN: One thing that I think would apply into the south west is that in a joint media statement announcing changes to PATS in 2009, the health minister and the then regional development minister stated that "the fuel subsidy will be reviewed on a six-monthly basis to reflect changes in fuel prices". Have those reviews been occurring, and what has been the outcome of those reviews; or, if they have not been occurring, why is that?

Mrs Chinery: They have not been occurring, to my knowledge, and I probably cannot give any further information to that. I suppose that part of having a centralised system is making sure that we do review and update that. But we actually do not have a mechanism currently in place to do that.

Hon LIZ BEHJAT: That statement was made in 2009, and it is now 2014. So there have been no reviews carried out over that period of time—in that five years?

Mrs Chinery: Correct.

The CHAIRMAN: What areas did we want to go to now?

Hon JACQUI BOYDELL: I have one question, if it is appropriate and can be provided to the committee. The reference you are making to your working party that is looking at improving the process of PATS, can you indicate what your time lines are for that and what the terms of reference are; and could you supply that to the committee, if that is okay with the Chair?

Mrs Chinery: Yes, if we could take that on notice. We have the terms of reference and we have an action plan, which we will provide you with the prioritised actions and time frames.

[*Supplementary Information No A2.*]

[11.00 am]

The CHAIRMAN: Just on the distances travelled, could you explain to us why cumulative distance travelled over a defined period of time is not taken into account when assessing eligible travel distance, if that makes sense?

Mr Moffet: Can I clarify the question? For separate applications, do you mean, or for the same application?

The CHAIRMAN: Sorry, there have been so many questions. The example is that if there is someone who needs dialysis three times a week, so over the period of the week they are going to be travelling greater distances than each individual, but it is taken into account that it is on each individual trip. They do not qualify if it is less than 100 kilometres.

Mrs Chinery: The current process is that each time you apply for PATS you have to put in a new form, so every occasion. Under the working party, we are actually trying to look at the form in a way that it potentially can make sure that people's needs, if they were like that, could be met. That is a process issue that we are currently looking at, and I think, Peter, it has been discussed at some length.

Mr Collard: I guess, in terms of allowing people to put down multiple trips per application and have that certified. I am not sure whether that answers your question; for example, if a person is travelling 80 kilometres to access a service, they are not eligible under the policy, but I guess your question is if they were travelling 80 kilometres three times a week, should they be eligible. The interpretation of the current policy at the moment would not accommodate that.

The CHAIRMAN: They would not be eligible at all?

Mr Collard: No. It may be dealt with as an exceptional ruling. If the resident made applications through the regional director, they would look at a number of different circumstances or criteria around whether that would warrant an exceptional ruling, but under the current interpretation of the policy, no, it would not.

The CHAIRMAN: That would not qualify?

Mr Collard: No.

The CHAIRMAN: I think that is also an issue for some people who live just outside that, so 95 kilometres from the nearest specialist centre. I know there has to be an arbitrary boundary written, but if you fall on one side of it, I suppose it is very unfortunate if you then need those medical things. You are right; to me it seems ridiculous that with dialysis, in particular, you know once a person has reached a point of needing dialysis, that is not going to ever change until such time as, unfortunately, they pass away or they get a kidney transplant. There is no way that you will just miraculously all of a sudden not need dialysis. It then seems that stress is added on to people at a time when you have the stress of having to keep on applying to PATS. I think in any review you do obviously that would be something to consider; if it was me doing the review, I would certainly be looking at that. Again, I think with cancer patients and chemotherapy, you know it is never generally one round of chemotherapy; it is going to be several rounds of it, and then radiotherapy, and then it might be other things as well.

Mr Moffet: I was just looking at the guidelines; it looks like those improvements last time round —

Mr Collard: Yes, they allowed for 70 to 100.

Mr Moffet: So, 70 to 100. There is some concession for the frequent travellers, but it does not include that concept of accumulated distance —

The CHAIRMAN: Accumulated rather than one-off?

Mr Moffet: Or block treatment sessions. That is true; it does not seem to incorporate that.

Mr Collard: And it does still just confine it to cancer and renal. There are a number of other conditions that do require frequent attendances, and if they fall under that 100-kilometre bracket, the policy does not allow for it. I guess as the metropolitan expands also, it is not going to be too long before 70 kilometres is the outer metropolitan area, or a suburb of Perth.

Hon JACQUI BOYDELL: You could argue that now, really, in some cases.

The CHAIRMAN: When we were talking about eligibility criteria for some of the allied health services, we talked about hearing with audiology and cochlear implants in particular, one of the

other what seems to be a very growing area of medical need throughout not just Western Australia but Australia and the world, is bariatric surgery. With bariatric surgery itself, there is a whole range of things you need to actually do before you even qualify for a surgeon to say, "Yes, you're going to get that", such as psychological counselling, dietary advice, and you are going need an exorcist—not an exorcist, an exercise —

Hon AMBER-JADE SANDERSON: Maybe!

The CHAIRMAN: — I say as I put another bit of biscuit in my mouth!

There is the exercise physiologist and things like that. What we have heard anecdotally—I do not want to sort of make it difficult for any people here—is that what happens is, quite often, it is squeezed in that sort of realm of, "You're seeing a specialist, and it might be just at that day that you might get to see these other people as well", but it is not an open process. Is that something you think needs to be addressed in relation to when we are looking at the expansion of those sorts of services?

Mr Moffet: Bariatric is probably a new one for me, but I do agree that where it is medically indicated, it does fit inside that sort of paramedic or broader allied health spectrum of care that is required for a treatment of a condition. I do not see how it would be differentiated, so long as it is medically indicated from audiology or specialised clinic needs or specialised dental. I think it is an example of a very similar service that wraps around the primary medical service.

Mrs Chinery: Some of the feedback we have had from people is that it is about—again, going back to that case management model—that if I am going down, I need all my appointments aligned. People do not want to be in Perth for weeks on end and then come back to Perth, and there is not a process to help people have their appointments as outpatients for surgical services coordinated. The PATS clerks, again, and some others, have inadvertently tried to do some of that, but I think that is an area where we could make some great improvements for consumers.

Mr Moffet: Has bariatric come up much?

Mr Collard: Not necessarily in terms of bariatric, but there are a number of other conditions, particularly cancer, where the patient may be under a cancer specialist and that cancer specialist might have a multidisciplinary team that is supporting that particular treatment. So, the patient is covered when they come to see a specialist, but if they are coming down to see a specialist physiotherapist or dietician or some other member of that particular team, they are not covered. That is, again, one of those grey areas where we often come into difficulty trying to interpret, should that be also covered as part of that specialist team.

The CHAIRMAN: Following on from that, it just strikes me, too, with the way cancer treatments are changing and the advances that are being made there, that the carer of the person may themself need specialist treatment to the point of view that it is for their health and wellbeing and care. I know, for instance, when I have visited Murdoch hospice, I have seen there that the cancer patients are well looked after, and they have a suite to one side where the carer can book in to have sometimes much-needed therapy, like psychological counselling but also massage therapy and other things that are trying to keep that person well while they are going through that thing. I suppose that is also something that is not covered and that would not even be contemplated under PATS at the moment, would it?

Mr Collard: Only if the escort or carer is accompanying the patient during their particular visit.

The CHAIRMAN: Yes, but they have to be deemed to be doing it because that person particularly needs something, not because they need something.

Mr Collard: Yes.

Mr Moffet: Yes.

The CHAIRMAN: It actually can become quite an interesting prospect, the whole thing. Are there any circumstances, if any, for PATS people to be covered by PATS when they are wanting to seek a second opinion? For instance, if they live in one of the regions—let us just choose Port Hedland—and there is a visiting specialist who they see so there is no need for them to travel to Perth, and that specialist says, "This is what I recommend; this is going to be your course of treatment", and that patient is not happy with that diagnosis or that suggested course of treatment, are they able to then seek a second opinion at a location other than Port Hedland?

Mrs Chinery: My understanding is that that would have to go through an exceptional-ruling process, because in the first instance they are to seek a specialist service provider locally. However, in saying that, that does not prohibit the person from putting through a request under the exceptional ruling.

The CHAIRMAN: Can you think of any recent examples where that has been applied for and approved? Would you have any of that on record?

[11.10 am]

Mr Moffet: I think there has been. This did not come up in the PATS context. There was a second opinion issue sometime in the last three or four months that I did see. It was not a primary PATS issue, but I think we did ultimately use PATS to support that second opinion. It was an exceptional set of circumstances in terms of the relationship between the medical practitioner concerned and the patient and family. I cannot specifically remember the circumstance, but this did come up recently where a second opinion was deemed necessary and supported by the specialist, and by regional administration at that point in time. I would say they are unusual circumstances and, generally speaking, there are other issues to address when there is a request for a second opinion to make sure that not only is it medically valid, but there is an issue about communicating with the family and making sure that the family has the sort of support they require around making decisions generally around their treatment and access to treatment. They are usually complex circumstances.

The CHAIRMAN: I suppose also it would fall under exceptional circumstances if there is a specialist coming to a region and the GP is saying they can see that specialist, but then if there is a need for that person to see a specialist earlier than when the visiting specialist is coming, can you then approve PATS travel under exceptional circumstances?

Mrs Chinery: Yes; it is a clinically based decision, so if they need to see a specialist sooner than when the specialist is coming to the region, then, yes, they will be sent on PATS. That does not need an exceptional ruling; that is a clinical decision by the general practitioner or the doctor they have seen.

Mr Moffet: If we have got a visiting cardiology service and someone has got an unstable cardiac condition and the GP or the referring practitioner is not happy to wait for a second opinion or for a specialist opinion, they would routinely be PATS-ed to Perth.

The CHAIRMAN: I will move to the area of the Auditor General's review of 2013. You have already spoken to us this morning and said that, as one of the consequences of that review, you have now looked at this trialling of the simpler form in the wheatbelt and in Port Hedland. I wonder if perhaps you can give us an update on other areas that were touched on in that review as to actions you have taken and where you have got to on that journey, please.

Mrs Chinery: The key finding was that the Auditor General's concerns were around governance. Whilst they did not find fraud or issues, they wanted to see improved governance around administration. One of the actions was to complete a thorough risk assessment of the administration of the scheme, which we have completed. A simple example might be that a PATS clerk might be processing a form of a relative. We have now put in place a conflict-of-interest form and they have a person to escalate it to. There were some other issues around delegation, so we have fixed the

delegation schedule to make sure that the PATS clerk has the right delegation. Peter, what were some of the other items around finances?

The CHAIRMAN: Can you expand on delegation?

Mrs Chinery: WA Country Health Service has as delegation schedule that allows an individual to sign off an amount of money, to authorise it, and we did not have that matching the authorisation for the booking of the flight. So, the PATS clerks were booking things without the delegation matching the obligations they had to administer day to day.

Hon JACQUI BOYDELL: Because the flight might have gone over their —

Mr Collard: Their delegation, yes.

Mrs Chinery: Peter, in terms of the finances, there were some other issues around Medicare number recording.

Mr Collard: I guess it was around validating that the applicant is who they say they are on the form, verifying that they are eligible for Medicare or an Australian resident, and they are a resident for that particular location. Whilst we have tightened up some of the controls around that issue, there still is a little bit of an ongoing issue in some locations, and we are still trying to sort that out in those particular locations. Again, we rely on the information that we receive from the applicant and also the referring general practitioner around that information. There were some back office issues around payments and verification of payments that go through the general PATS online system, so those areas have been closed off or are now monitored through our finance people. That has largely been closed off. Training was one of the issues around ensuring that all the PATS clerks were aware of their responsibilities. There are now three mandatory training modules for all PATS clerks that are involved in that, and they are required to undertake that training now before any new PATS clerk is given access to the system or starts processing PATS claims. We want to start to add some additional modules to that around customer service. We are currently doing some work around looking at suitable online customer service training that PATS clerks can undertake. They were probably the main areas that were identified.

Mrs Chinery: And maybe, Peter, where they felt that we were not checking that people were getting subsidies from elsewhere. We investigated that, but we do not have the powers or ability to check whether they are getting subsidies from elsewhere. So, on the new form, what we are trying to do is make sure that when you apply for PATS, you make a declaration that you are not abusing the system. These were the sort of administrative governance issues that they felt we needed to improve on.

Hon AMBER-JADE SANDERSON: What kind of subsidies are people able to apply for outside PATS that would make them ineligible for PATS?

Mr Collard: I think what the Auditor General was suggesting was that in some locations where people are given their $500 fuel voucher, that they should be using that before they applied for PATS or, if they are a pensioner, they should be able to use their free public transport ticket before they use PATS. We went back to them and said that is outside of PATS and there is no legal policy around that.

Hon AMBER-JADE SANDERSON: That is not the intent of the subsidy.

Mr Collard: They were some of the things that they suggesting we should be checking before —

Hon JACQUI BOYDELL: I hope you are not doing that.

Mr Collard: No, we are definitely not doing that.

Mrs Chinery: But it is a recommendation.

Mr Collard: But some of the other ones that we do try and check is if they are motor vehicle insurance or they are workers' compensation.

The CHAIRMAN: Sure, if there is a clearly defined benefit scheme.

Mr Collard: With some of those requirements, those people are eligible to claim travel assistance and so forth.

Hon AMBER-JADE SANDERSON: That is different.

Mr Collard: It is under those schemes. We try to follow up on those, and there are provisions on the form for people to indicate if they are getting those.

Hon AMBER-JADE SANDERSON: I would hate it to be the responsibility of a PATS clerk to ask them.

The CHAIRMAN: Yes, "Have you used your free bus ticket?"

Mr Collard: Yes. We responded to them, saying that that was outside the PATS policy and scope.

Mrs Chinery: There are some NGOs that do assist people as well and give them funding.

The CHAIRMAN: That was one question I was going to ask, because I know with some of the Aboriginal groups in particular, they will provide extra, or, in some instances, there have been no taxi vouchers provided under PATS, but then the NGO has come to the party and said, "We'll give you some taxi vouchers." That will not preclude that person from still accessing the PAT scheme; you just need to know whether those things are being accessed.

Mr Moffet: Yes.

The CHAIRMAN: One of the things around eligibility is somebody proving that they are eligible by saying who they are. The other thing we found is that these days, with people being very mobile around Australia, people do not necessarily come from Western Australia and they are doing the grey nomad thing, which certainly came up. The other one that presents some problems, and I want to know your thoughts on this, is with the fly in, fly out workforce. There seemed to be a little bit of difference in the way that people view where it is that they live. Are they residents of Perth or the Pilbara or the Kimberley, or wherever it is they are doing that fly in, fly out work? What is the eligibility criteria? How does the department view that one?

Mr Moffet: In general, it is the identified place of residence, so where that person's residence is. Generally, with a FIFO worker, that will not be in the Pilbara, for example, if it is a Pilbara FIFO worker. My understanding is that we currently administer the scheme on the basis of where they would identify that they actually live. Having said that, obviously, if a FIFO worker urgently needs assessment in between their normal frequency of shift, I am assuming we would ensure that they do get travel support for urgent reviews that are required, but, generally speaking, their residency would be determined as elsewhere.

[11.20 am]

The CHAIRMAN: I suppose that might be the case also with a FIFO worker where you would be going to the company that they work for to make sure there is no company scheme that they are eligible for or that it is a company responsibility to fly them out.

Mr Moffet: It is a difficult one. Industry employment conditions probably fall into a similar category as the other travel eligibility schemes that we talked about previously. We see PATS as a scheme for a particular purpose and we would not ordinarily approach them on their employment conditions, or the employers for that matter. We obviously work with industry on broader initiatives to support health services in regions as well. If it was a workers' compensation–related matter, clearly we would have providers, and doctors or others would work with their organisation to make sure they got the right care. As a generalism—correct me if I am wrong, Tina—we would administer the scheme impartial of their employment conditions.

Hon AMBER-JADE SANDERSON: I had a question about FIFO. It came up a bit in the north, obviously, and just some gaps in the policies and administration. I am interested to hear your point

of view of what those gaps are in terms of covering them, and is there not a greater role for employers to support, say, for example, a situational worker who is flying from a site to the mental health unit in Broome and requires some acute treatment there but his family is in Perth and it is better for him to go back to Perth? There is a grey area. Who is paying for it? Is he covered by PATS?

Mrs Chinery: You could probably contact the mental health unit. A policy was agreed early up when the unit first opened to ensure that if that case occurred with a FIFO—it was discussed—that person would go to Perth. It is not a set rule that all people have to go to the Broome mental health unit. Pilbara was considered an important case because there is actually a bed management system for mental health. I am not saying that people might not be sent up there because if there are no beds in the city, they are part of the beds that are available. There is a guideline around ensuring that potentially people can go to Perth if that is where their family is based.

Hon AMBER-JADE SANDERSON: If someone is injured on a site, for example, and is flown into a regional hospital and then requires further treatment—this may not necessarily be a PATS question—and the Royal Flying Doctor Service flies them down to Perth, does the taxpayer pick that up, or the employer?

Mr Moffet: If it is accepted as a workers' compensation scheme, it would be compensable so long as it was required treatment. RFDS would invoice for that service.

Hon AMBER-JADE SANDERSON: Does that occur?

Mr Moffet: Yes. The RFDS certainly manages its revenue streams, and so does St John Ambulance. In the first instance, it will occur in the public system until such time as there is an accepted claim, for example.

Hon JACQUI BOYDELL: Can I follow on from that question around the mental health unit? When we were visiting the Broome hospital, the mental health unit had a case of a FIFO worker and there was great consternation about how to manage him and who was going to pay for his flights. Maybe the social worker was new; I am not sure.

The CHAIRMAN: No; she had been there a long time.

Hon JACQUI BOYDELL: I think they granted him a flight through PATS for exceptional circumstances in the end.

Hon AMBER-JADE SANDERSON: The hospital paid for it because he clearly had a need to go and then they went through weeks of negotiation and trying to recoup that money through PATS to go down to Perth.

Hon JACQUI BOYDELL: It might not just be as clear as that, in our experience anyway. That might be worth following up.

Mrs Chinery: I will follow that up.

Mr Moffet: Generally speaking, who pays in the mental health transfer space is probably one of the least of the considerations. Bed access around involuntary beds around the state is really tightly managed and needs to be effectively managed, and then transport capacity is always a big issue for mental health clients. They often do not get to the same level of prioritisation as patients with urgent organic conditions. There is often an issue around the mental health transport requirements, which are more complex. There is usually a complex set of circumstances surrounding involuntary mental health clients. But I would say in our service system, if we need people to be closer to home or family, we absolutely make arrangements, whether it is PATS or road or air transport for that to occur. I am happy to look into the circumstances of the individual case.

Mrs Chinery: Can I just clarify that that was for discharge? Trying to get them out of the facility appeared to be the issue.

Hon JACQUI BOYDELL: Yes. He presented at the facility and he was a FIFO worker. They recognised that he needed to be closer to his family. I think his family were in Perth. Is that right?

The CHAIRMAN: Yes.

Hon JACQUI BOYDELL: They actually were in a bit of a quandary about how to manage his travel. They ended up paying for him and then decided to have an internal discussion around who would essentially fund it. If there is a protocol in place, I am not sure it is clear.

Mr Moffet: It depends if he has been discharged or transferred.

Mrs Chinery: We need to go and look at the case.

Hon AMBER-JADE SANDERSON: Maybe he was discharged. How does he then get back to Perth? There is a lot of grey area.

Hon JACQUI BOYDELL: There was.

Mr Moffet: If he was an interstate worker and had acute care and was discharged, there are often quandaries presented if they are not eligible for PATS. The same happens for grey nomads or retired visitors to the state. There is often a similar set of circumstances if you are not eligible.

The CHAIRMAN: I was seeing if we can find something from our transcripts of evidence. A person who gave evidence to us in Carnarvon was talking about patients needing to access rehabilitation services, not in relation to detox but further rehabilitation once the detox phase had taken place. Again, this revolved around some Aboriginal patients in Carnarvon. There is a scheme available in Broome that apparently is a very good scheme and has a very high success rate for people going there, being rehabilitated and not falling back into the trap of substance abuse again. PATS is not allowing them to travel from Carnarvon to Broome. You can go to Perth to a scheme. Again, a scheme has not been identified. I cannot think of the name of the one they were talking about in Broome. There is a program, and I will try to find it.

Mr Moffet: Milliya Rumurra.

The CHAIRMAN: Yes, that is the one. Is that a hard and fast rule that you cannot go from Carnarvon to Broome; you have to go from Carnarvon to Perth?

Mr Moffet: It would be, and also in terms of eligibility. Are rehab services incorporated into eligibility?

Mr Collard: If you are seeing a specialist in drugs of addiction, which alcohol would be part of, you are covered. Again, it would have to be that specialist that is running the program. If it was outside that specialist, it falls into that allied health grey area.

Mr Moffet: It would be an addiction specialist referral to Perth. I think the only addiction specialist in the state would be based in Perth.

Mrs Chinery: I would suggest that PATS would be faced with flying people to Perth to get them up to Broome. I would suggest it is around the policy and there are also probably some financial barriers to agreeing, even under an exceptional ruling. We would look at the cost as well.

Mr Moffet: We are happy to take it on notice, if it helps, to give you a bit more information about rehab services.

The CHAIRMAN: That would be terrific. That would be A3.

[*Supplementary Information No A3.*]

Mr Moffet: I am pretty sure they would not be eligible.

The CHAIRMAN: I will move to the area of subsidies for accommodation and hostels. We all know that the quantum given to people for accommodation is $60 if you are travelling singly, $75 if

you are with your partner or your carer, per night. I think there are some other add-ons to that in some circumstances. I want to talk about some of the things that we observed on our trip around. For me, the standout amongst all the evidence that we took was from an Aboriginal woman named Penny in Carnarvon and her story. I do not mind saying that it brought me to tears at the end of the hearing listening to her story. Penny's story is that she needs to travel to Perth for a cardiac problem that she has. She does have a carer—this is the potted version—who is her grandson, who is in his 30s. He is also a diagnosed schizophrenic that has come about by substance abuse, so he has his own issues surrounding that.

Penny told us the story that when she needs to come to Perth for treatment, invariably, even though she has asked in the past that they try and arrange her appointments for her at a time which is closer to when she receives her pension, she says it always seems to manage to be on a Monday or a Tuesday and that is when Penny does not have any money of her own in her purse.

[11.30 am]

She complies—Penny is 71 years old, by the way. She is an amazing lady that we met. She comes down to Perth with literally no money in her purse apart from the airfare that is paid for her and then she is accommodated at Jewell House. We know that Jewell House is closing down, and I think that is probably a good thing from what we have heard. This is her story: she is accommodated at Jewell House, she suffers from incontinence issues and therefore asks to be put in a room near a bathroom. The only place where she could be put is where the men are accommodated, and she finds it to be quite distressing and disturbing that she needs to use the bathroom very frequently in the evenings and she is always where the men are. In Jewell House she feels that she is unsafe, that it is unsanitary, and there are fights going on there all the time and there are people who come there dealing drugs and alcohol. These are the things that Penny was telling us about her experiences when she comes. It is not for me to say that this is what is happening; I am just telling you Penny's story. Then she says that when she comes she has no money in her purse for food, so she will not eat that night when she arrives because the soup kitchens that she might access are not there at that time because it might be later in the day. She certainly said that at Jewell House they get, I think her expression was that they give them "good tucker" in the morning, and she will get a good breakfast from them. But she said that because it is always in the back of her mind that she needs to be at her appointment at a certain time, she does not think ahead to say to the people at Jewell House, "Can you perhaps wrap me something up that I might be able to take with me?" She forgets to do that. She then goes to her appointment at the hospital where she might sit for three for four hours waiting to see the specialist and she will not eat any food during that time because nothing is offered to her. So, no food, no water—this is a woman with a cardiac condition. And then once she has had her appointment, again she still has no money in her purse, so she and her carer actually will go to the soup kitchen. She said she will get two cups of pea and ham soup and a bread roll and will take that back to Jewell House. By that point, as people can imagine—that is what brought me to tears—that I am hearing this story from an incredibly brave and eloquent and unwell woman in the twenty-first century that this is what is happening. I do not think that Penny is the only person that that is happening to, but that was Penny's story. I just think it is the twenty-first century and we are living in a very affluent society, yet that situation seems to be occurring. Again, there is the question of people sleeping rough in Wellington Square. Can you talk to us about what we are going to do address these sorts of situations?

Mr Moffet: I think you are right to observe that there are circumstances for particularly Indigenous people, but not just Indigenous people, navigating the system, coming into Perth where it does not go well. I think that is pretty well established. There are a range of services designed to support people. For example, my first thought for Penny is that we need to hook her up very closely to our Country Health Connection service, which manages all those sorts of issues. I do not know if she has had any exposure to them at all or if there are any issues there that we need to address. I guess this comes back to the sorts of services that we provide are case management services. The difficult

stuff around PATS is case management, both at the distal, or referring end, and at the Perth end. I would hope that the vast majority of our interactions with vulnerable people, which includes picking them up at airports, providing taxi vouchers, managing accommodation—and often that is more than one accommodation setting—transporting them to service providers and being part of those consultations, often, and managing meds and other services—legal and social around the edge of that—is part of what Country Health Connect does as well, as well as then their journey back home and, ideally—and this is often an area where we do struggle—communication of information back to the original referrer as well as the hospital. I guess the example that you have provided is an example where perhaps that system has failed. Whether Penny has been connected at all to that system, I do not know. But we can definitely make a difference on that front; we need to access her and connect her to the Country Health Connection service, I suggest. I do not know if you have any further information —

The CHAIRMAN: I was just looking at the evidence there, in particular for Penny we did not have that information, and we are yet to talk directly to the country connect people, but Penny's story certainly was not the only one. We have heard that that country connect system is broken and it does not work and that people are arriving at all sorts of times. I do not want to prejudge or harshly judge the country connect system until we have given them an opportunity to talk to us about what it is that they do provide and how well resourced they are or otherwise, but it would just seem to me that that is not a system that is really even there. One of the other things I noticed that Penny was saying is that she gets given taxi vouchers. Now it may not be from PATS that she gets the taxi vouchers—it may be from an NGO—but the issue she then has is that she uses a walking frame. I did see her frame and it is one of those rigid frames; it is not one of those pull-up wheelie ones—I know my mother has one of those. The issue she then has is that if she can get a taxi—two things: taxi drivers do not stop to pick up Aboriginal people, and that is a given, unfortunately, and it happens a lot; I have seen it myself. Secondly, a lot of the taxis, especially those that are gas-fuelled vehicles, tell her, "I can't get that walker into my car, so I can't take you." Whether that is their excuse for just not taking an Aboriginal person, I do not know. And so there are all these other issues that people are confronted with. I guess that is really an issue for us to canvass further with country health. Whilst we might connect her with that service, I am not sure what sort of service she would get if we did connect them.

Mr Moffet: Ostensibly, the service exists for all those reasons, so I would be interested in your deliberations. Are you hearing from them at a particular time?

The CHAIRMAN: I am not sure if we have arranged a hearing with them yet; we are still in the process. I think when we first embarked on this inquiry we thought it might be a relatively quick and easy inquiry, if you like, but one of the things that we have discovered as we have been going around—as you know yourself because it is very timely for our inquiry to be going on at the same time that you are doing your review—more and more things are thrown up as we go along and so we are not going to rush our deliberation phase or finish hearings on this until we feel that we have actually canvassed everything and opened up every little can of worms that there might be whether we want to or not. I think we will certainly be hearing from them at some stage.

Mrs Chinery: If I could maybe add to that case, Jeff. That might pick up an Aboriginal person that might be able to connect with country connect but there will be similar cases of people who are not Aboriginal. We are only funded for a subsidy scheme; we are not funded to do the case management. I think it is important. Just for noting, I know you are looking at the financials, but we have not received—necessarily over the years we had some funding in our base, we had the royalties funding on top and there was a gap in funding, and you will see that in the submission. I think the challenge is also that we are funded to do a certain amount and manage with that amount.

Mr Collard: And meals are not covered under the PAT scheme. Jewell House and two other Aboriginal hostels in the metropolitan area do offer meals, but most other accommodation units do

not offer meals and they are a lot more expensive. It is a challenge for our PATS people to try and find accommodation that is available within that $60 limit. Jewell House, that was run by the YMCA, and they did offer breakfast as part of that $60 rate, but very few other facilities will offer that.

[11.40 am]

The CHAIRMAN: I think in Perth that is the case, but we visited two hostels in Port Hedland and both were run on quite different models, which is interesting to see the way that they are run. One of the hostel situations that we saw in Broome is an arrangement that they have entered into with Broome-time Lodge where they have now got an incredibly good commercial arrangement working with that where they hold beds for them which they call their PATS beds where people who might not necessarily need to be in the hospital, but the doctor feels that they are not ready to be discharged fully to be returned to their community or the town that they have come from, so they are accommodated at Broome-time, but that is more than the $60, but that is covered because, as we all know, people in the health profession are very caring people and that is why they go into that profession; they are not prepared to see these people out on the streets and sleeping rough because they want them to get better and so they have made this arrangement. So, does the department just say, "You do what you need to do and we do not need to know about that"?

Mr Moffet: I am not familiar with the specific arrangements there, but, I guess, there is a combination of programs we provide right throughout the state called Hospital in the Home, which is obviously in the home setting, but for those people who do not have a resident home, there are times when we provide support and accommodation in different settings other than the hospital. The argument is that it is much cheaper to provide a day or a bed in a non-hospital setting than in a hospital setting. I am happy to look at what arrangements we have in place in Broome. I can say from my time in the NT, very similar sorts of issues prevail in Alice Springs and Darwin as well where to have a commercially viable operation for an accommodation provider, PATS alone does not tend to provide that service fully, so there were often transparent contractual arrangements with hostel providers, Aboriginal Hostels Limited and others, to provide a base capacity to offer 40 or 50 PATS beds in different locations. It is legitimate and they are normalised arrangements. It is just a commercial reality that providing accommodation and services around that accommodation in a remote setting—$60 to $75 a night is inadequate.

Mrs Chinery: WACHS has been seeking with our renal services, Jeff, we have been successful in getting investment for our hostels, capital. So, we have got to understand that there is a need to ensure that if we are going to bring clients back to the bush, they are going to need to access supported accommodation. It is within our service planning, but, ideally, as Jeff said, we would want another provider to run the hostel; that is not our core business for health, but we see it is integral to getting people closer to home.

The CHAIRMAN: I know there is a hostel in Broome, but the beds there are taken up full time by renal patients. There is a need there. They do not have the capacity then for pregnant mothers or mothers who have just given birth who, as you know, need that extra time but do not to be an inpatient at the hospital.

Mr Moffet: A hostel provider will have a number of revenue streams, state and commonwealth, and the assets are often gifted or supported by state or commonwealth as well. So, I think it is probably a real tapestry of revenue streams and in-kind and support arrangements from government that make hostel providers viable, quite frankly, whether that is Broome or in the Perth setting. We are currently finding with the imminent closure of Jewell House that we are exploring the market for other options around Perth and it is clear that we need to have the sort of arrangements that are going to require more than PATS support.

The CHAIRMAN: What is the date that Jewell House is due to close?

Mrs Chinery: December.

Mr Moffet: I think it is June next year now.

Mr Collard: June next year.

The CHAIRMAN: It is going to be there until June next year.

Mr Collard: It just closed last week as the YMCA facility, which was, basically, a backpackers'. That was providing a whole range of different client bases. Now it is just being used for PATS for a period of time until we can locate alternative —

The CHAIRMAN: It is purely going to be a PATS facility until June next year, so that is another nine months.

Mr Collard: Another nine months, but it has got 24 beds, which will continue to operate for PATS clients for that period of time while we do explore other options and alternatives to, I guess, accommodate those people.

The CHAIRMAN: I am sorry; my next question was going to be: what are you going to open in the short term instead of Jewell House? My impression was that it was closing quite soon. What would you say with regard to those claims—and Penny was not the only one who told us about the state of Jewell House itself and anecdotal evidence about what goes on there. It was certainly mentioned by a number of other people. If it is a PATS facility, who has the responsibility for law enforcement issues? If there is drug dealing going on in the corridors of Jewell House and if it is unsanitary and there are other forms of abuse going on there, which would seem to be the case, whose responsibility is it?

Mr Moffet: I guess law enforcement obviously would be the police.

The CHAIRMAN: But who is going to call the police?

Mr Moffet: YMCA are the managers of the service. YMCA in managing lots of hostels would deal with those sorts of issues routinely.

The CHAIRMAN: Even though they do not have any beds there now, they will manage it for PATS?

Mr Collard: YMCA are continuing to put in a manager. They will put in a night sort of supervisor, guard and provide some of the hostel services to continue to support PATS patients for that nine-month period.

Mr Moffet: It is a narrower range of service just around PATS clients; it is not the broader commercial backpacker —

Mr Collard: There will not be the backpacker and they also used to have homeless under the family and children services provided and they provided other services —

The CHAIRMAN: Apart from the other two Aboriginal hostels that you said are in Perth, is Jewell House the only facility that is purely now a PATS facility in Perth?

Mr Collard: It is the only PATS facility. There is two —

The CHAIRMAN: The other Aboriginal hostels are not just PATS.

Mr Collard: Yes; there are two hostels that are run by Aboriginal Hostels Ltd, which I think is a subsidiary of the government or they get a lot of commonwealth government funding.

The CHAIRMAN: Yes, they are commonwealth-funded.

Mr Collard: Then there is another 30-bed hostel facility that is run by Derbarl Yerrigan, which is the Aboriginal medical service in Perth. They run a 30-bed hostel service. Most of those facilities are, again, fairly full with renal and cancer patients and they are generally for Aboriginal clients.

The CHAIRMAN: So the only facility that is a purely PATS facility is Jewell House and that will be there until June 2015. What plans are there, if any, to replace those 24 beds post-June 2015 and where would that be located? Also are there any other plans in the pipeline with regard to PATS facility for a hostel situation at Fiona Stanley Hospital or the Midland Health Campus?

Mr Moffet: We have gone through an expression-of-interest process. I think that started late last year or early this year. We have had some outcomes from it, some unsuccessful, but we have certainly had some interest that we have been able to commence negotiations on. The accommodation replacements—I guess we are open for all options being considered. That is as varied as sort of Shelley to Salter Point areas as well as central Perth. We are looking at replacing that capacity really in the CBD or towards Fiona Stanley Hospital—that sort of corridor. So, we are in the early stages of negotiation with a particular proponent and we will be testing the market further. So, those beds will be replaced —

The CHAIRMAN: Expressions of interest for 24 beds or more than 24 beds?

Mr Moffet: I do not recall a specific number. Do you know, Peter?

Mr Collard: The expression of interest did not call for a specific number. It was just for people interested or being able to provide that type of accommodation.

The CHAIRMAN: Could you provide us on notice with a copy of that expression of interest information?

[*Supplementary Information No A4.*]

Hon AMBER-JADE SANDERSON: Is that for just PATS patients?

Mr Moffet: That is my understanding.

Hon AMBER-JADE SANDERSON: Aboriginal and non-Aboriginal?

Mr Moffet: Indeterminate.

The CHAIRMAN: All PATS patients.

[11.50 am]

Hon AMBER-JADE SANDERSON: With regards to a lot of the Aboriginal hostels as well, and because they deal with people with a range of circumstances as to why they need hostel accommodation, it is not necessarily appropriate to put, say, a birthing mother or cancer patients in with people with a whole range of other issues, such as homelessness and that sort of stuff. I think there does need to be much more specific accommodation for those people.

Mr Collard: King Edward Memorial Hospital runs an eight-bed unit for —

The CHAIRMAN: Is that Agnes Walsh?

Mr Collard: Yes. The Cancer Council also runs some accommodation. I think it has two units for cancer patients—Crawford Lodge and there is another one.

The CHAIRMAN: Tilbury, is it not, at Shenton Park?

Mr Collard: Tilbury, yes.

Mr Moffet: You are across the lot.

The CHAIRMAN: We have been learning a lot, I can assure you.

Mr Collard: There is also Ronald McDonald House that runs for children. There are various elements of accommodation around and obviously we have tried to utilise all of those. Most of them are in very high demand, though. Obviously, we then also do publish on our website some of the more commercial units around, and we do canvass them to see if they will offer special rates for PATS patients, but, again, that is in the commercial market.

Hon AMBER-JADE SANDERSON: On the commercial accommodation, it has been said—it did not come from hearings—that some of the commercial providers put a loading on for PATS patients because they get a subsidy. Is that something that you have come across?

Mr Collard: No; we try to get, as I say, a bit of a discount off their listed rates for our people. I am not sure about a loading. Often we will issue what we call a local purchase order to those providers for the accommodation, but, again, that would be only at the $60 rate and then if their rate is above that, it is up to them to get that from the client.

The CHAIRMAN: Just as an aside, I understand you have no control over these things, but it is just the things we learn as we go around. One of the things that was told to us is that Tilbury house itself is in Shenton Park and the house is located at the end of a 300-metre gravel driveway that has quite a steep incline to it and quite often patients are being dropped—it might be from country connection; it might be from other sources—at the bottom of the driveway and told, "There you go, buddy; off you go." Again, someone who is coming to town because they are having chemotherapy is not well. Evidence was given to us that residents of the area are seeing this happen and they are getting in their car and driving the person the 300 metres up the driveway. There are some really strange practices happening out there. I think if we could ever get to a thing where we had a seamless one scheme to accommodate everyone, we would live in an ideal world, I assume.

Mr Moffet: Are clients saying why that is the case? Have you heard that from patients themselves?

The CHAIRMAN: We have got that in evidence, I think, from John in Kalgoorlie. Was it a taxidriver? I am trying to think.

Mr Moffet: If it is a systemic issue, we are happy to follow that up as the inquiry is proceeding if it is an urgent issue.

Hon JACQUI BOYDELL: I think the point that was being made was that it needs to be more central. Shenton Park is too far away, nobody knows where it is and —

The CHAIRMAN: They cannot get there by public transport.

Hon JACQUI BOYDELL: — there is no public transport. To me, that was the main point. When in consideration of where you are going next with the new facility, that might be something to think about.

Mr Moffet: Yes. I do not think it was designed to replace Tilbury, though.

The CHAIRMAN: No.

Mr Moffet: I think it was really to accommodate it.

Hon JACQUI BOYDELL: I just have two other questions that are actually completely off that topic. Where you are dealing with patients, particularly in the Kimberley and the Pilbara, where they are being referred to a visiting specialist in, say, Port Hedland, it is about a four-hour drive. The terminology of your "closest specialist" is air travel to Perth. Do you think that that is an area that we need to consider? If you are in Newman, the only way to get to Port Hedland is to drive four hours over a rough road. It depends which way you go.

Mr Moffet: I would go on the bitumen

Hon JACQUI BOYDELL: Yes, I would. There have been unfortunate accidents on that inland road; actually, one of the nurses was killed, which I am sure you know about. So is there some consideration of "closest" meaning kilometres or time to get there? I would suggest, for me, it would be time to get there. Do you have any comment to make on that?

Mrs Chinery: I do not know if this will help; in fact, it probably will not help at all. Clinically, that is okay. I understand it is a long way, but in the bush sometimes you are used to that. It is just that if we have all people in the Pilbara travel down to Perth because it is more convenient in a plane, we will not have enough activity at Port Hedland to maintain specialist services, because part of the

model to have a doctor come and work in Port Hedland is: would we have enough of those people coming to him that it is viable for him to visit Port Hedland? In fact, there is a very fine balance here around making sure enough people, because the population is not that great in the Pilbara, are going to that regional centre so we can attract the specialist to work there in the first place. Having lived there and knowing that some Aboriginal people do not want to travel, I know getting a specialist closer to home is one of the strategic objectives of country health. I understand what you are saying. I suppose the balance is making sure that we sustain services close to home at the same time.

Hon JACQUI BOYDELL: I understand that entirely as well. I think that there needs to be some form within our process that allows for maybe that fine balancing, because actually, at the end of the day, it is the patient's interest that should come first. Whilst we might understand that we want to attract specialist services to the area and we want the Country Health Service to grow in the actual area, sometimes that might not be in the best interests of the patient outcome; that is all. We need a system that allows that, but I understand all the other drivers.

Mrs Chinery: There are a lot of local people who do not want to leave the Pilbara for care. In fact, in my experience, if the care was not there, they would not come to Perth, and they do not turn up for their aeroplane. My concern will be that there is a group of people for which it is extremely challenging to get out of the Western Desert, even to come into town. I think that that is one of the challenges for providing services in the country and deciding where people go.

Hon JACQUI BOYDELL: And we have certainly heard that evidence definitely.

Mr Moffet: I guess, in my regional administration of PATS in the past, if there are preferences to go to other specialists, the opinion of the resident specialist and their way of providing services is a really central consideration. For example, if you have paediatricians based in Port Hedland and there was a preference from a family that had moved to Newman to maintain the continuity of their paediatrician based in Perth that they had known for five or 10 years, it is a difficult circumstance. In reality, to provide a service, both outreach from Port Hedland but also for that specialist in Port Hedland to feel that they can maintain a level of skill and continuity with the patient, it is really the sort of service model that they are prepared to support as well that deems who can go to Perth at times. There are exceptional circumstances where the resident specialist will say, "Yes, I agree the most appropriate care on this occasion is to refer them to the city", but the policy framework is that the nearest available specialist is literally the nearest available specialist geographically, not in terms of travel time by different modes of travel. It is a tricky one, because you are trying to maintain a cohesive country system as well for the greater good of the population.

Hon JACQUI BOYDELL: Yes, I understand all that. I just think there needs to be that point where we know we have got economic drivers and we want to make sure we maintain the service. At the end of the day, it is the best alternative for the patient, I guess, that needs to be the number one priority.

[12 noon]

Mr Moffet: Yes; I do not think that is so much an economic driver. I think it is actually about sufficient volumes of procedural and sub-procedural work.

Hon JACQUI BOYDELL: It is an economic driver because if you do not have the sufficient volume, you will not attract the specialists.

Mr Moffet: I would not regard that as economic. What I would say is that in order for us to attract and retain—let us stick with paediatrics—paediatricians need to have interesting outreach services and a range of skills that test their scope of practice and also to feel that they do sit at the centre of the case management decision-making for public patients as well. Often in administering PATS there is a difficult balance between supporting specialist services in situ and disempowering those specialists in the way they care for their clients and the patient flows. My consideration is probably

less economic because it is often cheaper to provide a service out of Perth, for example, from an accommodation perspective, for families that come from here and more about the sort of model of care and the services to support interested specialists staying and providing services in those locations.

Hon JACQUI BOYDELL: I am not sure this is really a question, and it might pre-empt the working party reference that you are going to supply, but in Albany we heard of a case where a lady was being treated for a very rare condition which meant that she could only be treated on an annual basis, or her condition requires her to see a specialist once a year. Her condition is not going to change, but to access PATS she has to go back to the GP every year, pay the money to see the GP, get the referral to the specialist because the GP is only a step in the process to allow her to access PATS. Is that something the working party is looking at, where there is a diagnostic condition that requires you to see a specialist every 12 months, recognised clinically, but the administrative process is not supporting that?

Mr Moffet: I do not know if that is part of the working party's consideration; probably more frequent referrals, I think, fall into that category. I guess the question would be really a clinical question around this. If the GP is case managing the person's care, I would have thought annual reviews at that level would be appropriate.

Hon JACQUI BOYDELL: The specialist is treating —

Mr Moffet: There is no role for the GP?

Hon JACQUI BOYDELL: No; only to refer to PATS to get the referral to the specialist.

Mr Collard: Under the current Medicare scheme, specialist referrals are for only 12 months, so she would still be required to go to the GP to get a referral to go back to the specialist for a follow-up. That is why the PATS application—we could not deal directly with just the specialist because that would have lapsed, so it is a two-pronged issue.

The CHAIRMAN: You have to renew your referral every 12 months, do you not?

Mr Collard: Yes.

The CHAIRMAN: I need to set the record straight here, I think. The name of the place in Shenton Park is Milroy Lodge, not Tilbury Lodge. We referred to Tilbury when we meant to say Milroy. The situation John spoke to us about in his evidence was not country connect—he is not Aboriginal anyway—or a taxi; he did not qualify for taxi vouchers anyway, so he was not in a taxi; it was public transport. He talks about the situation in his particular circumstance where he got to a train station, he would catch the train from Kalgoorlie and get off the train at Midland. He could navigate his way around quite well to get from Midland to the Perth train station. From the Perth train station he is going to go to Subiaco train station. He is going to get on a bus in Subiaco and he is going to catch a bus to Milroy Lodge in Shenton Park and that stops at the end of the street. There ends his journey, and he still has a 350 to 400-metre walk in front of him up a hill. That was the situation. Even that seems to be quite an onerous thing for someone who is quite old with cancer and not qualifying. Anecdotally, he said to us—he used to be a taxidriver so he was quite knowledgeable in this area—if you were catching a taxi from the centre of the city, for instance, out to Shenton Park, you would have to pay $50 or $60. People cannot really afford to do that. That was the information surrounding Milroy Lodge.

We have finished 25 minutes early, so your parking meter should be alright! I would like to thank you very much for coming today. It has been a really useful information session. I have had quite a lot of experience with people from government departments giving evidence to inquiries, and it has not been such a pleasant experience in some circumstances because people have been very evasive about questions. You have really laid open the books, as it were and, obviously, you are just as keen as we are to see some changes in this scheme. I really want to commend you on the quality of the evidence you have given to us today; it will be invaluable for the inquiry. Thank you very much.

Mr Moffet: Thank you to you as well for making it easy to engage with; we appreciate that. Obviously, Peter, fundamentally, but the organisation, developed the position and the minister endorsed our submission. We are very supportive of the concepts put forward for your consideration in that submission, most of which we touched on today. PATS is a really difficult thing to administer; it is contentious and it is never enough, and that will always characterise PATS, I suspect. I also want to acknowledge—without diminishing any of the experiences you come across where perhaps we as an organisation have not performed as well as we could—every day and today right now, there will be dozens of people dealing with PATS in the bush and doing their best with the best of intent. I quickly acknowledge that we make a few mistakes from time to time, and we do not seek to do that. We see the scheme as an essential part of our care and our transport system. It is inevitable to use this system well is about getting good access to services, so any enhancements to increase access to services for country consumers we absolutely support and will continue to do our best to administer it in a fair and even way, but it will always be a tricky one that will attract some attention.

The CHAIRMAN: No doubt. From a committee point of view, I think it has been absolutely invaluable for us to go—even though we took over 160 written submissions, and you can read them and get a flavour for what is going on, when you go out there and see and talk to the people on the ground and talk to the PATS clerks about the difficulties they and the people administering and patients themselves face. At the end of the day, we are certainly seeing an improvement in the services to the regions, so I suppose that is one of the good things about making sure that the hospitals that are being redeveloped out that way can provide extra services. That needs to continue and grow.

Mr Moffet: We are not funded, as Tina says. The difficult thing for us is that we do like providing services for what we do, so we do try to make everything work for our consumers, but we are not funded for coordination beyond the Country Health Connection, centrally. If you do find that some improvements are needed or are possible, we will be very interested to explore and improve that à la Penny's story, for example.

Hon JACQUI BOYDELL: Everywhere we went, probably one of the opening statements the majority of people made was that they thought the scheme itself was one of the efficiencies of providing health care to country people. It is roundly recognised, especially —

The CHAIRMAN: It is very valued.

Hon JACQUI BOYDELL: Yes. It is very valued, and it is complex and emotional. I think that what this committee is doing is trying to make it easier for WACHS to administer the process, and I absolutely acknowledge that it is a valuable and fantastic program.

Mr Moffet: Just finally, I know we are looking at systemic things, and that is the importance, but if there are examples; for example, if you want to refer Penny's story to Peter or me—if you feel there are urgent issues—we are happy to deal with them as you come across them.

The CHAIRMAN: We might take you up on that.

Mr Moffet: We are interested in it. It is difficult for us; we sit in Perth as well and there are things we do not see and do not know about. I appreciate it is not systemic, but if there are individual examples you think we need to pay attention to, we are happy to do that.

The CHAIRMAN: That is good to know. Thank you very much.

Mr Moffet: Thank you.

Hearing concluded at 12.09 pm